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EXCERPTS FROM BRIEFS

Presented to

THE SPECIAL COMMITTEE OF THE SENATE ON AGING

by

Dr. Joseph W. Willard, Deputy Minister of Welfare,
Department of National Health and Welfare

(December 10, 1964)

and

Dr. K. C. Charron, Director of Health Services
Department of National Health and Welfare

(December 3, 1964)

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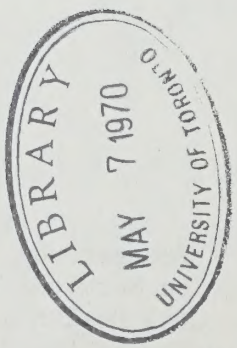

SOCIAL WELFARE AND THE AGED

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O T T A W A

WELFARE RESPONSIBILITIES OF THE DEPARTMENT

Under the Department of National Health and Welfare Act, the Department is given responsibilities for the promotion and preservation of social security and social welfare of the people of Canada in areas over which the Parliament of Canada has jurisdiction. It is in the exercise of these responsibilities that the Department has a concern for the welfare of older persons.

Welfare programs include several administered directly by the Department such as old age security, family allowances, youth allowances, family assistance, social welfare research and informational services and a number of others in co-operation with the provinces such as old age assistance, blind persons allowances, aid for the totally and permanently disabled and general assistance. There are other programs of which some aspects are directly administered by the federal department, while other aspects are federal-provincial in their nature and operation; the fitness and amateur sport legislation and the national welfare grants are examples of this type of program.

It is perhaps significant that while the need for some form of federal support for the aged was being discussed before the turn of the Century and gained some expression in the Government Annuities Act of 1908, it took sixty years from the date of Confederation to bring Canada's first social security measure for the aged into being in the form of the federal-provincial old age pension program of 1927. This and subsequent income maintenance measures for the increasing numbers of older persons in the population -- the generation which lived through two world wars and the depression years with low wage conditions followed by the inflationary influences of World War II -- have continued to rank high amongst the priorities of federal welfare policy.

The passage of the Old Age Security and Old Age Assistance Acts in 1951 was the second major attempt to meet the problems of income maintenance for a growing number of older persons. The Disabled Persons Act and the Unemployment Assistance Act of the mid-50's provided an additional source of income maintenance to older persons suffering from disabilities, or lack of income resources. The latter Act is particularly important because of the funds it has made available to support programs providing supplementary aid and care for needy persons in welfare institutions.

The Canada Pension Plan is designed to provide an earnings related type of support for aged persons and constitutes the first comprehensive measure providing protection against disability and loss of the breadwinner, as well as providing income support for the aged.

The departmental programs administered directly, as well as those undertaken in co-operation with the provinces, are the main publicly-supported income maintenance measures for the retirement years and, as such, constitute the foundation on which sound social services for the elderly can be built.

Beyond income security measures, the Department provides a number of services which assist the aged as well as other groups. These include welfare grants and consultative, research and information services.

Under the Welfare Grants Program, $1 million is available this year, and the amount will increase at the rate of $500,000 a year until a total of $2½ million is provided. The grants support social welfare training and research projects and provide a vehicle through which aid can be given for the development of a broad range of services including those for the aged.

The Department carries on a continuing welfare research service centred in the Research and Statistics Division. This research touches on many aspects of services for the aged and is in the course of being strengthened. Consultative services on problems facing the aged which are now provided to a limited extent in connection with the public assistance programs are also being further developed. The Information Services Division provides information on a wide range of welfare matters through the various media of communication.

In addition to these welfare services, the Department's Fitness and Amateur Sport Program has far-reaching implications for the provision of better recreational services for older people and for the building up of active recreational patterns in youth and middle age which can lead to a fuller capacity for leisure activities in later years.

The services administered by or supported through the Welfare Branch of the Department of National Health and Welfare cannot be viewed in isolation. They form an integral and important part of a network of services provided through a number of federal agencies -- the Health Branch of the Department for hospital care and other health services, the Central Mortgage and Housing Corporation in the case of housing, the Department of Labour for employment and technical and vocational training services related to older workers and the Department of Forestry, Citizenship and Immigration

and Veterans Affairs for the respective measures they provide for the rural population, Indians and war veterans. Similarly the services of the Welfare Branch must be viewed in the context of the welfare and related services provided for the aged through the provinces, municipalities and voluntary agencies.

INCOME MAINTENANCE PROGRAMS FOR THE AGED IN CANADA

Government Expenditures

In the fiscal year ended March 31, 1963 government expenditures on old age income maintenance in Canada totalled $824,074,000, about 21 per cent of total expenditure on health and welfare and about two per cent of the gross national product, as compared with about 1.5 per cent a decade before. The financial burden fell mainly on the federal government, which provided $779,228,000 or almost 95 per cent of all government expenditures on income maintenance for the aged.

The comparable figure for 1963-64, without costs of additional supplementation through the unemployment assistance program, is $886,807,662, a rise of $507,260,567 or 133.6 per cent from the comparable figure, $379,547,095 for 1953-54. This increase is accounted for both by increased levels of benefit and the rising number of older persons.

In the same period, expenditures on old age security rose from $339.0 million to $808.4 million, with the average annual percentage rise being about 3.5 to 4 in years when the rate of benefit was not increased. At the same time federal expenditures on old age assistance rose from $20 to $39 million.

The number of recipients of old age security has risen steadily, latterly at about the rate of 25,000 a year during the same period.

In view of the fact that old age security expenditures have become increasingly higher and that these benefits have been provided free of a test of means, the question of how much of the expenditure is recovered through income taxation has been brought up from time to time. While the answer is difficult, some interesting observations can be made from the 1964 Department of National Revenue report "Taxation Statistics". During the taxation year 1962 total old age security payments amounted to $720,624,668. The percentage of these old age security benefits declared as income by income taxpayers was only 13.9 per cent.

Federal payments under old age assistance have risen from $20.3 million to $39.2 million in the last 11 years. During the same period the number of recipients has risen by only some 12,000, from 93,273 in 1953-54. The number of

recipients receiving the maximum assistance has remained relatively constant over the period, varying between 77 and 81 per cent.

FEDERAL PROGRAMS

Old Age Security

The Old Age Security Act became law in January 1952. The Act provided for the first time for pensions without means or need tests to all persons aged seventy and over who met prescribed residence requirements. The original pension was $40. Twenty years of residence in Canada immediately prior to commencement of pension were required.

A number of amendments to the Act, the last effective October 1, 1963, have raised the monthly rate by stages to $75.

To qualify for pension a person must have resided in Canada for ten years immediately preceding its commencement or, if absent during that period, must have been actually present in Canada prior to it for double any period of absence and must have resided in Canada at least one year immediately preceding commencement of pension. Payment of pension may be continued for any period of residence outside Canada if the pensioner has resided in Canada for at least 25 years after attaining the age of 21 or, if he has not, it may be continued for six consecutive months exclusive of the month of departure from Canada. The program is administered through regional offices located in each provincial capital.

The pension is financed on the pay-as-you-go method through a 3 per cent sales tax, a 3 per cent tax on corporation income and, subject to a limit of $120 a year, a 4 per cent tax on taxable personal income. Yields from these taxes are paid into the Old Age Security Fund; if they are insufficient to meet the pension payments, temporary loans or grants are made from the Consolidated Revenue Funds.

Since the Old Age Security program came into effect, approximately one-third of all applicants have been persons who formerly received Old Age Assistance, Blind Persons Allowances or Disabled Persons Allowances. In March 1964, there were slightly under 47,000 recipients of Old Age Security pension who were receiving supplementary assistance paid by the provinces, and the cost of which is shared by the Federal Government.

For the fiscal year 1964-65 it is estimated that the total expenditures for Old Age Security pension will be $885,500,000; for 1965-66, $905,000,000; and for 1966-67, $920,000,000.

The proposed Canada Pension Plan legislation provides for two amendments to the Old Age Security Act. The pension paid under the Act will after 1967 be adjusted to changes in the cost of living, in the same way as will benefits under the Canada Pension Plan. Provision will also be made for old age security to become payable as early as age 65, with the amount slightly, but permanently, reduced for each month between one's age on claiming the pension and one's 70th birthday. The lowering of the age would start at 69 in January 1966 and proceed in annual stages until, in January 1970, pensions become available at age 65.

Canada Pension Plan

Some notes on the Canada Pension Plan, as set out in Bill C-136 which is now before a Joint Committee of the House and Senate, are included here to provide a picture of the income security provisions that are being proposed as well as those which are now in being.

The intent of the Canada Pension Plan is to provide for a nation-wide system of social insurance that will establish a basic level of security for all Canadians whatever their individual circumstances, whatever moves they make, and whatever economic changes occur.

All persons earning over $50 a month or $600 a year in wages and salaries or $800 a year in the case of the self-employed will be covered. The upper income limit on which contributions are paid will initially be $5,000. Contributions will be required by persons from age 18 to 70. While the pension will be a fixed portion of average earnings, provision is made for earnings in earlier years to be revalued in proportion to changes that have taken place in the general level of earnings and all benefits will be adjusted annually in line with the cost of living.

An employee will pay contributions at the rate of 1.8 per cent of that part of his wage or salary that lies between $600 and $5,000 a year. His employer will pay an equal amount. A self-employed person will pay 3.6 per cent on the same range of self-employment earnings.

The retirement pension will be one quarter of adjusted average earnings on which contributions have been made. That is to say, a man who has been earning $240 a month will have a pension of $60 a month; a man who has been earning $5,000 a year or more will have a monthly pension rate of $104.17.

Retirement pensions will be paid at age 65 provided the man or woman has in fact retired from regular work. A small amount of earnings -- up to $75 a month -- will not affect the right to a full pension. Higher earnings will

result in the pension being progressively reduced, for persons under age 70. Unearned income -- for example, from a private pension plan or an annuity does not affect the entitlement to pension from age 65. From age 70 the right to pension is absolute, regardless of any earnings.

A full pension will be earned by making contributions for 90 per cent of the time from the start of the plan -- or, for young people, from age 18 -- through to age 65. The other 10 per cent is an allowance to save people from being penalised, in their pensions, if they have been sick or unemployed.

Under the same rules, a woman who works for, say 30 per cent of the time will get one-third of a full pension. For example, she might work for four years, marry and stop work, then work again for 10 years after her children are grown up. She will thus earn in total a pension of a third of what it would have been if she had earned at the same rate throughout the time between her eighteenth and sixty-fifth birthdays.

A man who continues to work and contribute for some or all of the years between 65 and 70 will get the benefit of his earnings during those years, in place of any earlier years when he did not work or had a lower level of earnings.

These rights to retirement pensions will take full effect when the plan has been in operation for ten years -- i.e. in January 1976.

After one year a man or woman who has contributed in 1966 and who is age 68 may receive a pension of one-tenth of the full level. After two years, the pension will be available to retired people at age 67 and will be two-tenths of the full level. By 1970 -- i.e. after four years of contributions -- the pension will be available from age 65 and the benefit level will be four-tenths. Full pensions will be reached in 1976.

As the Bill also provides for benefits to widows and orphans and in the case of disability or death of contributors, it constitutes a new comprehensive approach to social security in Canada.

Because pensions are a field of common federal and provincial jurisdiction, the Bill provides that it will not be operative in a province in which a comparable plan is established under provincial legislation. This could be done either from the beginning or later. In the second case, the Bill provides for the transfer to the province of assets and liabilities relating to that province's contributors.

The Bill provides for co-ordinating its administration with that of any provincial legislation for a comparable plan. This co-ordination has been worked out in detail with Quebec, which intends to have such legislation.

FEDERAL-PROVINCIAL PROGRAMS

Old Age Assistance

Under the old age assistance program cash benefits are provided to persons who have attained the age of 65 years and fulfil the income, residence and other requirements set forth in the Old Age Assistance Act and Regulations.

The provinces and territories have passed legislation authorizing the payment of old age assistance and made agreements with the Government of Canada as provided by the federal Act. Before an agreement can be completed, the proposed provincial scheme for the administration of assistance must be approved by the Governor in Council.

Applications for assistance are made to the provinces. In order to obtain the federal share of 50 per cent, provincial authorities must make their decisions on applications and their payments to recipients in accordance with the terms and conditions set forth in the federal Act and Regulations. Provincial claims for the federal share are presented monthly.

Old age assistance is not payable to a person in receipt of a pension under the Old Age Security Act or an allowance under the Blind Persons Act, the Disabled Persons Act or the War Veterans Allowance Act.

The Old Age Assistance Act establishes an Advisory Board consisting of two representatives of the Government of Canada and two representatives of each of the provinces with which agreements have been made, to recommend alterations to the regulations considered necessary or advisable. The Act provides for a province's consent to amendments to the regulations.

The number of recipients of old age assistance, 106,407 as at July 31, 1964, has consistently been about 21 per cent of the population 65 to 69 years of age. As a rule, recipients of disability allowances apply for old age assistance on attaining age 65. At age 70, recipients of old age assistance are transferred to old age security. The number transferred during a fiscal year is about 23,000.

Each fiscal year, the provinces furnish federal authorities with certain statistical information on some 30,000 to 35,000 new applicants. This information is published in the reports of the Minister of National Health and Welfare to Parliament on the administration of old age assistance.

The latest report published is for the fiscal year 1962-63. In that year the total number of applications was 35,821 of which 31,677 were approved. Of the persons granted old age assistance 13,746 (43.4 per cent) were males and 17,931 (56.6 per cent) were females. There were 20,613 who applied at age 65. Of this number 8,108 (39.3 per cent) were males and 12,505 (60.7 per cent) were females.

Regarding marital status, there were 8,337 married males and 7,795 married females, 2,531 single males and 1,694 single females. The separated were 1,222 males and 1,141 females and the divorced, 95 males and 114 females. There were 1,561 widowers and 7,187 widows.

Statistics on recipients in urban and rural areas showed 17,922 in cities and towns, 9,918 in villages, 3,033 on farms and 804 not recorded under any of these headings. The number in cities and towns was 56 per cent of the total.

Of the 31,766 new recipients in 1962-63, there were 14,632 (46 per cent) who owned their own homes. Those living in rented houses or apartments totalled 6,308 (20 per cent) and in rented rooms, 3,134 (10 per cent). The number living with children and other relatives was 6,177 (19 per cent). Of this number 1,694 (27 per cent) were males and 4,483 (73 per cent) were females. There were 1,045 in public institutions, 138 in private institutions and 243 not classified.

In the applications not approved, numbering 3,329, there were 2,170 (65 per cent) where the applicants had income in excess of the amounts allowed. Applications made at too early an age numbered 575 (17 per cent). In 247 cases (7 per cent) the applicants were over 70 years of age or were receiving other pensions or allowances that debarred them from old age assistance. The residence rules excluded 137 (4 per cent). There were 104 who refused to furnish information and 28 with whom the provincial authorities had lost contact.

The provinces provide statistics on their total case loads as at the end of each fiscal year showing the percentage of recipients receiving maximum and reduced assistance payments. At March 31, 1963, there were 82,821 recipients out of a total of 103,159 receiving $65 a month, the maximum payment at that date. This figure represented 80.28 per cent of recipients.

Federal payments to the provinces on account of old age assistance for the fiscal year 1962-63 amounted to $38,179,056. The Old Age Assistance Act was amended with effect from December 1, 1963, to increase the maximum assistance in which the Government of Canada may share from $65 to $75 a month and to increase the maximum amounts of income allowed by $120 a year in the case of unmarried persons and $240 a year in the case of married persons. Federal expenditure for 1963-64 was $39,208,181. Estimated federal expenditure for 1964-65 is $44,975,000.

Disabled Persons Allowances

Although allowances for Disabled Persons do not constitute an income maintenance program designed for the aged, as such, they have sufficient importance for the older person not yet eligible for old age pension or assistance and who is incapacitated, for them to be referred to here. (In the same way, though to a lesser extent because of the considerably smaller numbers involved, Allowances for the Blind Persons assist the older person who is or becomes blind).

The Disabled Persons Act of 1954, as amended, provides for federal reimbursement to the provinces for allowances paid to permanently and totally disabled persons aged 18 or over who are in need and who have resided in Canada for at least ten years immediately preceding commencement of allowance or, if absent from Canada during this period, have been present in Canada prior to its commencement for a period equal to double any period of absence. To qualify for an allowance, a person must meet the definition of permanent and total disability set out in the regulations to the Act, which requires that a person must be suffering from a major physiological, anatomical or psychological impairment, verified by objective medical findings; the impairment must be one that is likely to continue indefinitely without substantial improvement and that will severely limit activities of normal living. The federal contribution is 50 per cent of $75 a month or of the allowance paid, whichever is less. The province administers the program and, within the limits of the federal Act, may fix the amount of allowance payable, the maximum income allowed, and other conditions of eligibility. All provinces are granting allowances at the $75 monthly maximum.

Unemployment Assistance (General Assistance)

All provinces have general assistance programs for persons in need. Their coverage extends to elderly persons who may be in need because they are among the relatively small number of persons over the age of sixty-five who lack

the ten years of residence required for eligibility under the old age assistance and old age security programs.

The provincial general assistance programs, which are successors to the poor law and relief provisions of earlier decades, are known under various names, including social assistance, social aid, and general welfare assistance. In recent years, they have been substantially improved as a result of stronger provincial legislation and supervision and as a reflection of greater public acceptance of the desirability of making better provision for this residual group of needy persons. While the programs are still administered in part by the municipalities in a majority of the provinces, there has been a trend towards direct provincial administration of longer-term cases.

The improvement in the general assistance programs has been particularly marked since the enactment of the federal Unemployment Assistance Act in 1956 and its amendment in 1957. While this program excludes mothers' allowances payments and the costs of health care and general administration, it provides for sharing in fifty per cent of other assistance payments to persons who are in need. Federal reimbursement to the provinces under the Unemployment Assistance Agreements during the current year is estimated to be in the order of $115 million.

Unlike the old age assistance, blind and disabled allowance programs, the unemployment assistance program does not involve parallel measures at the provincial level, but rather makes possible federal sharing in the provinces' existing general assistance measures. The conditions of eligibility are determined by the provinces, and they also set the rates of aid that they grant to the persons covered. In general, these programs are on a needs test basis. The Unemployment Assistance Act provides for sharing in payments to persons being cared for in welfare institutions (see item IV. (i) (a)) and in the additional assistance or supplemental allowances granted to persons who require aid over and above that provided under the other income maintenance measures.

Within the general assistance programs in the provinces are a number of special measures for long-term aid that are of special relevance to older persons. These are the widows' allowances programs in Ontario and Quebec, social allowances in Manitoba and Alberta and the supplemental allowances referred to in the previous paragraph. Payments made under these programs are shared under the Unemployment Assistance Act.

Widows' Allowances in Ontario and Quebec

Ontario and Quebec are the only two provinces that make provision for allowances for needy widows and unmarried women of 60 years or more who have more than one year's residence. A program of widows' pensions was in effect in Alberta until June 1961, when the new social allowances program became operative.

In Ontario, assistance to widows and unmarried women is governed by regulations under the General Welfare Assistance Act. Under this program, which came into effect in May 1963, provincial allowances of up to $75 a month are available to widows and unmarried women of 60 years of age or more whose liquid assets do not exceed $1,000 and whose annual income, including the allowance, does not exceed $1,260. The definition of "unmarried woman" includes a wife whose husband is a patient in a mental hospital, sanatorium, a hospital for the chronically ill or a nursing home, or is a resident in a home for the aged where he has been a patient for at least six months; a wife whose husband is imprisoned in a penal institution for six months or more; a woman who is divorced and has not re-married; and a woman who has been living separate and apart from her husband for seven years or more. A recipient is entitled to receive medical services without cost under any agreement in force between the Province of Ontario and the Ontario Medical Association.

The Quebec program of allowances to needy widows and spinsters of 60 to 65 years of age became operative in September, 1961. An allowance of up to $75 a month may be granted provided the applicant does not have cash or liquid assets in excess of $1,000 or an income, including the allowance, of more than $100 a month.

Social Allowances in Manitoba and Alberta

Alberta and Manitoba have similar provisions for provincial allowances to persons who, because of physical or mental incapacity likely to continue for more than 90 days, or who, by reason of their age, are unable to earn an income sufficient to pay for the basic necessities for themselves and their dependents. Their Acts also provide for the payment of social allowances to needy recipients of old age security pensions, old age assistance, blind persons allowances and disabled persons allowances.

In Alberta, the amendment to the Public Welfare Act authorizing such allowances became effective June 1, 1961. Persons receiving aid at that time under the Widows' Pension Act or the Supplementary Allowances Act could elect to transfer to the new social allowances program or continue under these programs, but no further applications for aid

were accepted under either of these programs. The regulations under the Public Welfare Act set out a maximum food and clothing allowance for social allowance recipients, but no schedule is set out for shelter and other necessities; these are calculated on the basis of amounts accepted as necessary for minimum standards of health and decency in the community in which the applicant lives.

In Manitoba, the Social Allowance Act, 1959, proclaimed effective February 1, 1960, provides for provincial allowances to categories of persons as in the Alberta Act and, in addition, provides that an allowance may be paid to or in respect of a person who is unable to care for himself and requires to be cared for by another person or in an institution or home for the aged or infirm. The regulations set out the cost of the items considered basic necessities and also the items to be taken into consideration in the calculation of income.

Supplementary Allowances

The income of elderly persons who are receiving old age security pensions, old age assistance, blindness allowances and disability allowances may be supplemented in all provinces if need exists. Five provinces -- British Columbia, Alberta, Manitoba, Ontario and Quebec -- make special provision for supplementary aid to needy recipients of any of these four income maintenance benefits, and Saskatchewan makes provision for provincial supplementary aid to recipients of old age security pensions or blindness allowances. In other provinces, such assistance is available under the general assistance program administered by the municipality or, in Newfoundland, by the province.

As noted earlier, supplemental allowances are shareable under the federal Unemployment Assistance Act when they are granted on the basis of need. In March 1964, some 20,000 recipients of old age assistance and 47,000 persons covered by old age security were receiving supplementary aid under provincial assistance programs, with federal sharing under the Unemployment Assistance Act.

The following is a brief summary of the programs in the six provinces mentioned above. With the exception of British Columbia, residence requirements are the same as those for other needy applicants for provincial or municipal aid as the case may be.

In British Columbia, the Old-Age Assistance Board administers supplementary aid to recipients of old age security pensions, old age assistance, blindness allowances or disability allowances. The amount of the allowance, to a maximum of $24 a month, is determined by the budget deficit

method. Applicants must have lived in British Columbia, without receiving supplementary assistance or as a responsibility of another province, for three years immediately prior to the date of the proposed commencement of social allowance, the last year of which must be continuous. Allowances also continue to persons who qualified for aid on a means test basis under the former program.

In Alberta, supplementary allowances, as noted above, are payable under the Public Welfare Act by the province on the basis of need. Those persons who were receiving supplementary allowances of up to $15 a month payable under the Supplementary Allowances Act and who did not elect to transfer to the new social allowances program that came into effect in June 1961 continue to receive allowances under the former program.

In Saskatchewan, provision for provincial supplementary allowances for needy recipients of old age security pensions or blindness allowances is made under regulations under the Social Aid Act. The amount of assistance is determined by the budget deficit method according to a schedule of rates for items of basic maintenance set out in the regulations. Provision has also been made for the continuation of supplementary allowance on a means test basis for persons receiving supplementary allowances under the former program who are unable to qualify under the new regulations governing the budget deficit method of determining need.

As noted above, needy persons in Manitoba who are receiving a pension under the Old Age Security Act, assistance under the Old Age Assistance Act, or an allowance under the Blind Persons Act or the Disabled Persons Act may receive provincial aid on the basis of need under the Social allowances Act.

In Ontario, supplementary aid to recipients of any of the four maintenance programs may be granted under the General Welfare Assistance Act. This aid is administered by the municipalities and by the province in unorganized territory. The province reimburses the municipalities for 80 per cent of supplementary aid up to a maximum of $20 a month.

In Quebec, a supplementary allowance may be paid to recipients of governmental allowances (old age security pensions, old age assistance, blind persons allowances, disabled persons allowances, allowances to needy mothers, and assistance to widows or spinsters 60 to 65 years of age) who are living in certain specified areas regarded as high cost areas by the Lieutenant-Governor-in-Council. This assistance is administered by the Quebec Social Allowances Commission.

SERVICES FOR THE AGED IN CANADA

Introduction

Just as adequate income maintenance through social insurance transfer payment programs and public assistance is essential for older people, so also are the services that enable them to live comfortably, creatively and independently for as long as possible, and with appropriate social and recreational outlets. A summary of some of the services available through provincial and voluntary auspices is included here to indicate the framework of total services available, and to give, by inference, some indication of its strengths and of its gaps. A number of organizations providing these services have previously presented briefs to the Committee and have described their individual programs in detail. In this report, an effort is made to avoid duplication of this information, while offering a brief overall sketch of total services.

Fundamental to an acceptable standard of living is good housing. Housing for the elderly under the National Housing Act has been the subject of a brief by the Central Mortgage and Housing Corporation. The summary included here is limited to the legislative provisions for various types of accommodation for elderly persons in each province and is intended to supplement the data already provided.

Other welfare services which are being developed or extended and which mean a great deal to elderly people include meal services, day centres which provide recreation and other services, homemaker services, counselling and friendly visiting.

The educational, vocational and other services designed to assist creative living are omitted as not within this Department's terms of reference, though their importance is stressed as part of the overall picture. What is included here is not an exhaustive list, but is intended simply to touch briefly upon some of the major areas of welfare services for older people.

Institutional Care

Historical Background

The development of institutional care for the sick and needy of the western world stems from the Judaeo-Christian tradition in which the virtues of charity were emphasized as a religious duty and as a manifestation of brotherly love. Institutions grew up under the auspices of the Christian church at least as far back as the third and fourth centuries.

An interesting feature of some of the earlies institutions is that they were operated along functi al lines as special facilities for the sick, the aged and the needy. This differentiation was lost later when the problems of poverty, age, illness, illegitimacy and delinquency became linked in people's minds and gave rise to the development of congregate institutions. In spite of periodic and severe criticism, these mixed institutions in which the aged person could receive little special attention persisted until very recent times, and in some places their last vestiges are only now being removed. During the Middle Ages, alms houses and houses of mercy, as they were known, were operated by monastic orders in most parts of Western Europe.

In England, this system of religious institutions was broken by the dissolution of the monasteries in the sixteenth century and was replaced gradually by poor houses established under the Poor Relief Act of 1601, its various amendments, and its successor of 1834. The principle under which all types of derelict human beings were crowded into custodial institutions in order to save them from neglect and indolence, and to protect a society which offered few alternative measures, remained basically unchanged until the eighteenth century when voluntary hospitals began to emerge. Poor relief was based on the principle of "less eligibility", implying that recipients of relief should not enjoy conditions of life as good as those of independent labourers of the lowest class. Thus the general mixed-work house often had a bleak, repressive atmosphere which was deliberately maintained to discourage the able-bodied poor, including the aged, from seeking admission.

The pattern of the English work house had a considerable influence on the development of institutions in the Atlantic provinces of Canada, some of which had earlier adopted the Elizabethan-type of poor law. Municipal institutions were established in Nova Scotia and New Brunswick, while Newfoundland and Prince Edward Island developed central institutions operated by the provincial governments.

In Quebec, which inherited the traditional system of monastic institutions from France, both congregate and specialized institutions operating under religious auspices were developed widely throughout the province. They became, and remained well into the twentieth century, the basic type of provision for those in need, including the aged. Thus the Quebec Public Charities Act in 1921, which offered public support on an organized basis for persons experiencing various types of need, was initially envisaged as extending only to institutional care.

Ontario was less directly influenced by European approaches to institutional care than the other older provinces. Thus while provision was made in the 1830's for the establishment of municipal houses of industry, this aspect of the English poor-law tradition did not take early root, and county homes were not developed in any number until close to the end of the century. From the 1840's, however, voluntary houses of refuge began to be established and were to be found in all the larger centres prior to the development of municipal homes. Many of the voluntary institutions were set up under religious auspices, while others represented broad community participation. The voluntary institutions began to receive grants from the province at an early stage; the grants were placed on a systematic basis in 1874 and made conditional upon the acceptance of provincial supervision in the same year. Ontario thus developed parallel and complementary public and voluntary institutions.

The institutional approaches worked out in Ontario were influential in the western provinces, especially Manitoba which also developed both public and voluntary institutions. Until recent years, Alberta had relatively few older citizens, and it is only within the last decade that it established its province-wide system of provincially-built but locally-administered homes for senior citizens. A somewhat similar situation obtained in Saskatchewan which, in addition to establishing geriatric centres, has made considerable use of the provisions of the National Housing Act for the building of hostels for the aged in connection with public housing developments. British Columbia, with large numbers of retired persons, has seen the development of considerable numbers of voluntary institutions and of boarding and nursing facilities operated under private auspices.

Recent Trends and Developments

In recent years, the trend throughout Canada has been towards specialized institutions both for health care and for sheltered accommodation. Within these broad groupings, different types of facilities for the aged have multiplied. There are, in most provinces, at least four main categories of welfare institutions for the aged: boarding houses, hostels, homes for the aged and nursing homes, in addition to specialized health care facilities in geriatric, chronic, general, tuberculosis and mental hospitals.

In all provinces there are provisions for public support and supervision of welfare institutions, and in some provinces financial aid is available for the construction of new institutions under public or voluntary auspices.

In addition to broad-scale measures designed to assist the institution and benefit its residents as a whole, the provinces, and in some cases the municipalities have provisions for needy persons requiring institutional care. These latter provisions usually form part of general assistance programs which are also supported by sharing provisions of the Unemployment Assistance Act.

Since 1956, the federal government has shared, under the Unemployment Assistance Act, in approximately half the payments to needy persons being assisted in various types of welfare institutions referred to in the Act as "homes for special care." These homes include the traditional types of welfare institutions, as well as homes for the aged, nursing homes, boarding homes and hostel accommodation. Over 30,000 persons in homes for special care are currently covered by the sharing provisions of the Unemployment Assistance Act, and federal reimbursements to the provinces for needy residents exceed $25 million annually.

This federal measure, and the Hospital Insurance and Diagnostic Services Act, in addition to providing federal funds for the maintenance of both health and welfare institutional services, have assisted in the rationalization of institutional accommodation. One of the most significant trends in the period during which these Acts have been in effect is the accelerated development of specialized institutional accommodation and services and better defined utilization procedures.

Facilities and Utilization

Available statistical data on facilities for the institutional care of aged persons derive from a number of different sources and must be considered as incomplete and not fully accurate. However, some information is presented, which is reasonably valid for the purpose of estimating the overall provision of beds with the various forms of institutional care, including both health and welfare institutions.

In aggregate, the estimate is that, inclusive of hospital facilities, approximately 109,400 beds, representing about 77.2 beds per thousand population 65 years of age and over, were allocated for the institutional care of aged persons in Canada in 1962-63. In other words, on any particular day, nearly eight of each 100 persons 65 years of age and over were residents in some form of institution, rather than in the community at large. It is believed that for the population 75 years of age and over the percentage of persons actually situated in one form of institution or another might rise to about 15 per cent of the population over 75 years of age.

With respect to the total provision for institutional care of the aged, eight of the ten provinces were fairly close to the national average number of beds per thousand population 65 years of age and over, varying from 92.9 in Alberta to 69.5 in Prince Edward Island and 68.5 in New Brunswick. The other two Atlantic Provinces had much lower ratios -- 45.6 in Nova Scotia and 39.2 in Newfoundland.

In addition to these variations among provinces in the total institutional provision, there were wide differences in the extent of various categories of facilities, reflecting such factors as divergent needs, variations in terminology and classifications, and policy differences with respect to including long-term care institutions as hospital facilities under the Hospital Insurance Program or considering them as nursing facilities under the Unemployment Assistance Program.

"Homes for special care" supported by payments through the federal-provincial unemployment assistance program comprised more than one-half of the total count of beds allocated for aged persons. Some 1,631 separate facilities reported a combined total of 58,000 nursing and domiciliary care beds at the end of the year 1963. It has been assumed for purposes of these statistics that all the patients or residents occupying the beds in "homes for special care" are aged persons; this is only a first approximation but is reasonably close to the truth.

A high proportion of these residents suffer from physical infirmities requiring personal and nursing care, and many are completely bedridden. Others who are in relatively good health have no other suitable place to live. Nearly all of them may be said to require certain minimal services which are not, in the present state of community services, available to them elsewhere.

The constantly changing health status of residents in these facilities makes it difficult to count separately the nursing care beds as distinct from domiciliary care. Definition of the distinction between these categories was left to the discretion of the provincial authorities supplying the data. About one-quarter of the reported beds, mostly in the Province of Quebec, were unspecified as to whether they are for nursing or domiciliary care.

Among the total of beds where the type of care was specified, there was a majority of domiciliary beds, but in Quebec most of the reported beds were nursing beds. If the ratio of nursing to domiciliary beds among specified beds in each province is assumed to be similar for the unspecified beds, we may conclude that in aggregate close to one-half of the 58,000 beds may be considered as nursing beds and about one-half may be considered as domiciliary beds.

In reviewing the beds in "homes for special care" in each province in relation to the aged population, we find that seven provinces were fairly close to the national average of 40.8 beds per thousand population over 65 years of age, with a variation from 36.4 in Alberta to 46.6 in Manitoba. The Province of Saskatchewan was somewhat lower with 28.7 beds per thousand, while Newfoundland had 22.9 and Nova Scotia had 19.5 beds per thousand persons over 65 years of age.

Eight of the ten provinces reported a majority of domiciliary beds in "homes for special care"; Saskatchewan and Alberta had up to 80 or 90 per cent of the beds in the domiciliary category; Newfoundland, Prince Edward Island, Manitoba and British Columbia had well over two-thirds of their beds classified as domiciliary; Nova Scotia and New Brunswick also had a majority of domiciliary beds; Ontario had slightly more nursing than domiciliary beds; Quebec reported most of its beds in the nursing category.

It is apparent that the available statistics on beds in "homes for special care" leave much to be desired. More information is needed to define and clarify the various types of residents under care and the levels of service being provided in these facilities in the various provinces.

Supervision and Licensing

Provincial supervision of homes for the aged and nursing homes is generally exercised through inspection and approval and a system of licensing. Furthermore, charitable institutions must be approved in order to qualify for maintenance payments on behalf of their needy residents. The legislative authority for this supervision may be found in health acts and regulations, in social assistance legislation, and in statutes specifically governing homes for the aged or nursing homes.

Standards of Accommodation and Care

The changing emphasis to a protective health environment rather than straight residential care in facilities for the aged has been accompanied by more attention to standards of care. One emerging pattern has been the upgrading of levels of service in facilities approved for participation in the hospital insurance program, as well as in facilities approved as "homes for special care" under the unemployment assistance program. More restorative services are being developed. Another encouraging development has been the formation of associations of nursing home operators in several provinces and a National Association of Nursing Homes which is in process of formation.

Regulations setting out standards of care cover a number of areas and differ substantially in their scope from province to province. Among other things, they may govern personnel, nutrition, medical care, occupational and recreational activities, admission and discharge procedures, records, and returns. In a few areas such as admission and discharge procedures and record keeping, the regulations are fairly specific, and there is some degree of uniformity between provinces. In other areas, however, they are general in their content, as, for example, the requirement that meals of "adequate quantity and quality" be served to residents of municipal and voluntary homes, or that, where possible, adequate recreational, rehabilitative and hobby-craft facilities be provided.

Standards of accommodation relate, among other things, to the type of building and its location, to the equipment and facilities in the home, and to sanitation and fire protection. In some cases, the regulations are specific in their requirements. They may require, for example, that there be at least a specified area of space per resident in sleeping rooms, that prescribed bathing and toilet facilities be available, or that the temperature of the home be kept above stated minima during the day and night. Standards are usually set out in general terms, however, with the administrative authority maintaining control through the exercise of discretion in granting licenses or giving approval. Approval is based on detailed information submitted with the application and on reports of inspections. Reliance is also placed on reports of certificates of approval obtained from officials such as fire commissioners and medical officers of health.

Maintenance Payments

Payments on behalf of needy persons in homes for the aged and nursing homes are made by the provinces, and in some provinces by municipalities, through the regular social assistance program or under legislation which deals with institutional accommodation in particular. The municipal share in those provinces where this exists varies from under ten per cent to one-third of the assistance payments.

Generally the amounts paid are based on per diem or monthly rates established by the province. These rates are calculated on the basis of actual costs of operation in the care of publicly-owned homes, and are negotiated in the case of voluntary or proprietary homes. Some provinces, such as British Columbia, Alberta, Ontario and Quebec, set out maximum amounts payable for a given type of care in non-public homes. The other provinces accept individual rates in different homes after satisfactory negotiation.

Recipients of old age assistance, old age security or other statutory allowances are required to contribute towards the cost of their maintenance. The recipient retains a small amount (generally varying from $5 to $12 a month) as a personal comforts allowance.

The combined provincial and municipal payments are shared by the federal government under the terms of the Unemployment Assistance Act. The federal contribution amounts to 50 per cent of expenditures on behalf of the needy persons maintained in accepted homes for special care described above.

While the rates of assistance, including those paid for care in accepted homes and the conditions under which assistance may be granted, are determined by the province or municipality, the rate that is shared federally may not exceed what an individual might reasonably be expected to pay for accommodation of a comparable kind and quality. Payments are made only on behalf of persons who would not normally be cared for in general chronic or convalescent hospitals, tuberculosis sanatoria or mental institutions. Also, payments made for medical, hospital, nursing, dental and optical care, and for drugs and dressings are excluded from claims under the agreements. The costs of routine nursing services provided in institutions such as nursing homes are, however, considered shareable.

Proprietary nursing homes and private hospitals listed as participating facilities in the hospital insurance programs of some provinces are reimbursed by a daily contract rate for standard ward care provided to beneficiaries. The federal government shares the cost of approved services in listed facilities under the Hospital Insurance and Diagnostic Services Act.

Capital Grants

Provincial capital grants for sheltered accommodation facilities are available in seven provinces: Newfoundland, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan and British Columbia, while an eighth province, Alberta, has assumed the entire cost of building and furnishing 50 municipal homes for the aged on municipally owned land. Generally, the grants are made for both municipal and voluntary homes and cover a stated portion of capital costs. The maximum portion payable in grants is 20 per cent in Newfoundland and Saskatchewan, 33 per cent in Manitoba and British Columbia, and 50 per cent in New Brunswick and Ontario; there is no set proportion in Quebec. Some provinces also provide grants for the renovation of existing facilities.

In most cases, payment of a capital grant is conditional on approval of plans and specifications for the home by the provincial authority, thus enabling the provinces to exercise control over the standard of the accommodation that is provided. Other conditions, which vary from province to province, also affect the payment of grants. In British Columbia, for example, residents of assisted homes must be ambulatory, and their medical needs must be such that they could be cared for by a visiting medical practitioner. In Manitoba and British Columbia, an organization receiving a grant for a home must contribute 10 per cent of the total cost, obtained in such a way as not to mean a debt on the accommodation. Both provinces set a maximum limit on the permissible income of residents, and Manitoba has a minimum age limit for residents.

Federal loans are available to non-profit organizations under the provisions of Section 16 and 16A of the National Housing Act. Such loans for residential institutional accommodation may be approved for up to 90 per cent of construction costs to 5 3/8 per cent interest repayable over a term of up to 50 years.

HEALTH CARE FOR ASSISTANCE RECIPIENTS

Dr. K.C. Charron has already presented to the Committee material on health services relating to the interests of the Health Branch of the Department of National Health and Welfare. An area of health care not covered in that presentation, because of its close association with welfare programs, has to do with the group of older persons covered by various provincial health care measures for public assistance recipients. Among this group are included those old age security recipients who are covered by the supplemental allowance programs offered by a number of provinces which provide health care as an associated benefit.

Traditionally, the health care required by needy persons has been provided in the public wards and outpatient departments of hospitals, and through the donated services of medical practitioners. With the advent of hospital insurance and of special programs of the types outlined below, the former methods of meeting the health needs of assistance recipients are declining in importance, and adequate services are being looked upon as an integral part of public assistance programs. A question which has affected the implementation of this principle, however, is the fundamental one of whether health services should be developed for particular groups or whether the emphasis should be upon the development of comprehensive health programs covering the whole population. This question is being closely studied by the federal government in the light of the recommendations of the Royal Commission on Health Services and is also being given close attention in the provinces.

HOUSING

Low-rental housing accommodation for the elderly has been built in Canada largely by voluntary groups assisted by provincial capital grants in some provinces and by federal loans advanced under the National Housing Act administered by Central Mortgage and Housing Corporation.

Federal Aid

The most widely used method of financing low-rental accommodation for the elderly has been through the assistance rendered to voluntary non-profit groups by the long-term low-interest loans available to limited-dividend companies under Section 16 of the National Housing Act. Although no specific mention is made of elderly persons in the Act, many projects for them have been financed under the provisions of this Section.

Housing for the aged may also be built as part of public housing projects undertaken in accordance with Section 35[1] of the National Housing Act, which provides for federal-provincial sharing of the costs of constructing fixed or low-rental projects.

Loans made under Section 16 of the Act may equal 90 per cent of the lending value of the proposed project. They currently bear interest at the rate of five and three-eighths per cent per year and are repayable over a term of up to 50 years. Should a sponsoring group receive a capital grant from a governmental authority or private person, the federal loan may be less than 90 per cent in order to ensure some investment by persons in the community where the project is to be built.

To qualify for a loan a group must form a limited-dividend company. Any group of public-spirited citizens including service clubs, charitable foundations, church groups or business leaders wishing to provide low-rental accommodation for the elderly may form such a company. A loan may not be made to a municipal authority. Municipal governments, however, may participate in and subscribe to a limited-dividend company.

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[1] The former Section 36 became Section 35 under the 1964 Amendment to the National Housing Act.

In requesting a loan a company must provide specific evidence of the need for the proposed housing project. Plans must be approved by Central Mortgage and Housing Corporation which must also be satisfied that the company will be capable of administering the construction and operation of the project and that it has a definite plan for the disposal of the project after the loan has been repaid.

The limited-dividend company must agree to a fair and reasonable ratio between the rents to be charged and the incomes of the admissible occupants. Rents may not be changed without the permission of the Corporation. The company may establish a rent reduction fund and any contributions, gifts or bequests to it must be used solely for the purpose of reducing rentals.

Projects are usually comprised of self-contained dwellings, detached or semi-detached, in the form of row cottages, duplexes or small garden or other types of apartments. Those for whom the accommodation is intended must be able to manage in the type of dwelling provided.

Loans may also be made for accommodation of the hostel or dormitory type.

Provincial and Municipal Aid

There are a variety of arrangements in the provinces under which advantage may be taken of Sections 16 and 35 of the National Housing Act. Some provinces also have additional legislation to provide for provincially financed housing. Municipalities may subscribe to the stock of limited-dividend companies, make grants of money or land for housing to be used specifically for the elderly and provide municipal tax exemptions for such projects. The various programs are outlined below.

HOMEMAKER SERVICES

Agencies offering visiting homemaker services have had to limit service for the most part to families when the mother is ill, but because of the increasing demand for care to elderly people, a number of agencies are attempting to extend services to this group as their resources permit. There are about 55 visiting homemaker programs in Canada; some 30 of these are operated by the Red Cross Society in three provinces. The remainder are provided by a variety of organizations: visiting homemakers associations, family service agencies, children's aid societies, multi-function agencies, and the Victorian Order of Nurses.

The Red Cross and some 10 other agencies are currently providing homemaker services to the aged. During the month of May 1963, for example, 144 elderly persons received service in Ontario. Elderly persons normally require service for one-half day a few times a week; full-time service may be provided for persons who need more attention but wish to live independently. In addition to doing household tasks and shopping, the homemaker may perform personal services such as taking the elderly client out to a movie or for a walk or writing letters for him.

Homemaker services have proved valuable in preventing physical and mental deterioration and in either postponing institutionalization or making it unnecessary. Such service is less expensive than most institutional care and is often more satisfactory to the elderly person because of the sense of independence and security it gives him.

The extension of homemaker services is regarded as urgent by those concerned with the welfare of families and individuals. Agencies supplying homemaker services cannot meet the demands upon them because of the shortage of personnel, and problems of recruitment and training are receiving close attention. The Canadian Welfare Council through its national Committee on Visiting Homemaker Services provides leadership in improving standards of employment and of service and in enlisting public support for homemaker services.

Some impetus to the expansion of services is being given by the availability of public funds for this service, in particular in the Province of Ontario. A number of provinces contribute in whole or in part to the cost of homemaker services for needy persons. Ontario, however, is the only province with a specific Act relating to homemaker services, viz., The Homemaker and Nurses Services Act, 1958. This Act authorizes municipalities to furnish their own homemaker and home nursing services or to contract for service with organizations approved by the Minister of Public Welfare. The province shares with the municipality the cost of providing this type of aid to persons who cannot pay all or part of the cost of the service.

MEAL SERVICES

The need for meal services to the elderly in their own homes is widely recognized, but problems of finance and organization have, to date, seriously hampered efforts to provide them. Brantford, Ontario, is the only Canadian city with a "meals-on-wheels" service, although in some other cities, notably Ottawa, Halifax and Winnipeg, studies and some experimentation have been made. No public funds are available; where services are or may be provided extensive use is made of volunteers, and the clients are asked to pay a portion of the costs.

COUNSELLING

Counselling for the elderly is provided as part of the general program of family service agencies, some of which have developed or are developing special staff for this work. Counselling is also done by the staff of some public welfare departments. Centres for the aged, such as the Good Companions in Ottawa and the Age and Opportunity Bureau in Winnipeg, provide a counselling service for members. Vocational counselling is provided through the National Employment Service.

Specialized counselling services are limited in number at present, but services are being extended and experimental programs are being inaugurated. As an example of the latter, the Ontario Welfare Council Section on Aging, in co-operation with the Lakeshore Senior Citizens' Council, the Y.M.C.A., service clubs and the local branch of the Family Service Association, initiated a pilot project of advisory service for the elderly in November, 1963. The project is centered at the Y.M.C.A. and has a ten-member volunteer staff of retired business and professional people who are available two days a week to discuss problems with elderly people and acquaint them with community services.

RECREATION

Organizations or centres serving the elderly are found in most of the larger cities, and towns and in many smaller ones. They vary from pensioners' organizations meeting once or twice a month to recreation or day centres which are open five or six days a week and provide meals and other services in addition to social and recreational opportunities. Clubs may be sponsored by municipal recreation authorities, community associations, national women's organizations, local welfare councils, service clubs, churches and trade unions. There are also clubs for retired employees and old age pensioners. The proportion of persons served, however, is modest.

While the provision of recreational facilities and programs appears to be the major function of most clubs and centres, an examination of their activities reveals a wide range of services, usually designed to meet the various needs of the aged or to supplement other programs. Day centres, where they exist, are open all day for all or most of the week. Members participate in craft and social activities, perform community services such as visiting in hospitals or repairing toys for needy children, enjoy low-cost meals, have the use of libraries and television sets, organize choirs, orchestras and drama groups, and benefit from counselling, employment services, and, in some instances, medical or nursing services. These centres are usually financed through United Funds or Community Chests, but also make extensive use of volunteers.

Many more social or community clubs exist throughout the country. Sponsors tend to be churches, service clubs and, in some instances, municipal bodies. These clubs operate on a more modest basis, meeting perhaps once or twice a week and using existing facilities such as church halls and community centres. They perform a valuable service by providing opportunities for elderly people to come together and enjoy the companionship of people with mutual interests and concerns.

The Province of Ontario assists in the establishment of social centres through the Elderly Persons Social and Recreational Centres Act of 1962. This Act, the first of its kind in Canada, provides for a provincial grant to meet 30 per cent of the cost of building or altering premises for use as a centre, if the local municipality will assume 20 per cent of the cost.

Day Care Programs Offered by Homes for the Aged

An interesting development is the day care program set up to meet some of the needs of the applicants awaiting admission to homes for the aged. The program of the Toronto Jewish Home for the Aged, for example, provides for physical care including rest and dietary requirements, and recreational, social and cultural needs. No medical care is given. Day residents attend from 11 in the morning through to supper and the evening program at the home. Another example is the House of Providence in London, Ontario, which has recently introduced a day care program for daily visitors. It is hoped eventually to make the service available to any senior citizen wishing to participate.

Fitness and Amateur Sport Program

The federal Fitness and Amateur Sport Act of 1961 is designed to encourage, promote and develop fitness, as well as participation in sport, amongst all age groups in Canada. Under the program up to $5,000,000 can be made available annually each year for the purposes of the Act. While considerable emphasis is naturally placed on the encouragement of active recreational pursuits amongst the younger population, this by no means precludes assistance to many forms of recreational work amongst older people. In addition, and possibly as important, the development of community activity being assisted through the program can result in more active recreational habits amongst the middle aged, which can persist, if in modified forms, as they grow older.

Under the Act assistance relating to older persons might come from a number of sources.

Through the important co-operatively administered federal-provincial program, under which the federal government assists the provinces in the carrying out of projects by reimbursing them for 60 per cent of the costs, leaders and instructors of different kinds can be trained and provided on a full or part-time basis for group recreational activity. The impact of this program is already being felt in many localities; its use for groups of older persons could be expanded.

Research on fitness supported by the Act may throw light on many problems of the older person, because of its emphasis on cardio-vascular and other conditions related to fitness, which have special reference to older persons. The expanding Information Services program will eventually embrace good instructional material on many sports and activities which are of interest to the older person.

In addition to the federal program, and with its assistance, community recreational services related to fitness are being developed in all provinces and these could increasingly embrace recreational activities for older persons.

OTHER COMMUNITY SERVICES

Friendly visiting of elderly persons at home or in institutions is carried on by members of service clubs, church groups, branches of the Canadian Red Cross Society, old people's clubs and other interested groups. In Ontario, the Red Cross Society gives a course of one complete day or two afternoons or evenings on friendly visiting. It has also prepared a handbook for visitors. In Ottawa, friendly visiting is a joint project of the Ottawa Welfare Council and several other organizations. Plans are developing to train volunteer supervisors or convenors of friendly visiting groups and those who wish to become visitors. In Winnipeg the Age and Opportunity Bureau has provided training for interested chruch groups.

In addition to visiting, the volunteers may do shopping, assist with hobbies, arrange outings and generally treat the elderly persons as if they were relatives.

PLANNING AND CO-ORDINATION FOR THE AGED

There are wide gaps between the aspirations we in Canada have for the well-being of the aged and the programs and services available to promote it at the present time. The purpose of this section is to review the measures for planning and co-ordinating that have been developed to reduce those gaps.

The need for planning becomes more apparent when one examines the way in which services for particular groups -- such as the aged -- have grown up. Canada, along with other western countries, appears to go through four stages in recognizing and reacting to the problems of our aged people. In the first stage, the problem is viewed as an economic one, and programs are formulated to alleviate poverty. The conception of the problem is then usually broadened to include special living arrangements and health care. Thirdly, provisions are made for leisure time, counselling and other supportive services. Finally, a need for planning and co-ordination to bring the community's resources to bear on the needs of the aged becomes apparent. Many western countries have largely completed the first stage and are well into the second and third stages. A number of nations are now entering the fourth stage.

In Canada planning and co-ordination have grown within a broader social context than that of aging at both the national and local levels.

The local planning bodies in Canada have been the community welfare councils now found in some twenty cities and regions. These organizations, while interested in a broad spectrum of social problems, have included the field of aging within their activities for many years and on a variety of fronts. In the Province of Quebec, where they have been adapted to and have grown up on the diocesan plan, they cover rural as well as urban regions to a degree not attained in the rest of Canada or in the United States. The larger question of linking social, economic and physical community planning at the local level is only beginning to be grappled with in Canada.

Provincial planning and co-ordinating structures, of a temporary or permanent nature, are found in four provinces. Following the First Ontario Conference on Aging, the Ontario Society on Aging was founded in 1957; in 1963 it merged with the Ontario Welfare Council. In 1964, the Ontario Legislature established a special committee to enquire into the needs and problems of the aged for that province; it is now at work.

The Government of Saskatchewan, following its conference on aging in 1960, established an Aging and Long-term Illness Survey Committee responsible for research and planning in that province. The Committee has published several useful reports and organized a number of local, regional and provincial conferences. This project was discontinued in the autumn of 1964.

Nova Scotia has established an ad hoc committee within the Department of Public Welfare to receive representations and to prepare its brief for the Special Committee of the

Senate on Aging. A Provincial Welfare Council was established in Quebec in 1964. It includes the field of aging amongst its several concerns. Parenthetically, it may be noted that, in its recent report to the Lieutenant-Governor-in-Council, the Quebec Study Committee on Public Assistance recognized the need for research and planning and for close collaboration between government departments and between departments and voluntary organizations.

At the national level, comprehensive social planning is carried out under the auspices of the Canadian Welfare Council which was founded in 1920. It established a standing committee on the aged in 1954, which, amongst other activities, carried out in 1962-63 a major survey of living arrangements for the aged under a grant received from the Central Mortgage and Housing Corporation. It has also instigated and is co-sponsoring with a wide range of national organizations, the first Canadian Conference on Aging, to be held in 1966.

In the federal government, concern for the aged has been directed primarily to the field of social security, beginning with the Government Annuities Act of 1908 and culminating in the present proposals for the Canada Pension Plan. An Interdepartmental Committee on Older Workers was established in the Department of Labour in the early 1950's. The Central Mortgage and Housing Corporation has made significant contributions to the aged, not only through loans for low cost housing, but also through the leadership it has given to research and planning.

The Department of National Health and Welfare has established research and consultant positions, some of which are related to the field of aging. However, while planning and co-ordination are undertaken within the departments, interdepartmental planning and co-ordination have not yet been firmly developed except in relation to specific programs such as the Canada Pension Plan.

A COMPREHENSIVE APPROACH TO AGING

A comprehensive approach to the condition of aging requires, as indicated above, a complex of services which are related to one another and integrated with those for the general community, and planning and co-ordinating structures designed to ensure that available resources are fully and effectively utilized in the provision of the needed services. An essential resource, which is often overlooked or discounted, is the group for whom the services are intended -- the aged themselves.

There is ample evidence from older people that they wish to go on living as closely to normal as possible, to be regarded as having a continuing contribution to make to society, to feel wanted, to be close to friends, relatives and former associations, and at the same time to enjoy some real independence. These are normal desires, and it makes good sense, economically as well as socially, to try to create and maintain the conditions under which the process of aging can be seen and experienced as a normal phase of life. This implies the conservation of the resources of older people in terms of their special skills, their interests, their maturity and experience, and their desire and capacity to continue to contribute significantly, not only to their own well-being, but to that of the community of which they are an essential part.

The implication is clear. Stress must be laid on the normal, rather than the abnormal aspects of aging, on participation in the community rather than, or in addition to, contribution by the community. To use the social welfare field as an illustration, the trend in income maintenance programs is to make the fact, rather than the cause, of need the major criterion in establishing eligibility for financial assistance. Thus, where old age has been a condition for the receipt of assistance, now the need for assistance, whatever the reason, becomes the more important factor. Again, health problems, once a significant cause of insecurity, are being dealt with through various medical plans and, of course, through hospital insurance. In other words, by planning to meet the needs of the total community, it is possible to include the special needs of the aged without emphasizing or encouraging what is now seen to be an artificial definition of old age as a period of dependency.

A comprehensive approach to aging, therefore, is one in which features with a positive focus are given as much attention as the ameliorative aspects of aging, such as the need for income maintenance. It involves imaginative social planning, full co-operation between public and voluntary bodies, and, above all, a determination to create the conditions under which the aged can make a maximum contribution to the community, in the process of which they retain their place in the scheme of things.

The Welfare Branch of the Department of National Health and Welfare in the administration of its programs can make some of the contributions required for the attainment of this "whole" approach to a new era for the older person. The proposed adjustment of the Old Age Security program and the proposed Canada Pension Plan measures that are now being considered by Parliament would, if passed, improve over the years the basic income prospects for Canada's older persons. Current negotiations and discussions with the provinces regarding Old Age Assistance, Disabled

Persons Allowances, Blind Persons Allowances, and Unemployment Assistance offer promise of more adequate supplementation of basic income for those in need. The Welfare Grants program forms a flexible instrument to explore and provide preventive community resources in the interests of older people. The Fitness program can assist in providing important recreational opportunities and cultivating the capacity to enjoy them. Departmental resources for research, consultation, and the production of informational material can be strengthened in keeping with the needs of a growing older population.

However, these are only parts of a comprehensive approach to one of today's persistent human concerns; to maintain within the community the creative capacities of those who spent their lives in building it.

In the national interest generally and for the total welfare of our aged in particular, responsive Canadians in their private and public capacities, can help to give the work of your Committee an adequate perspective.

- by helping to shift the emphasis from filling gaps to taking a new look at the whole range of services and activities which could assist the aged to realize their fullest capacities

- by balancing the concern for adequate income maintenance provision with a concern for adequate social services

- by changing the emphasis on categorical assistance to one group to an emphasis on total social responsibility and so setting the condition of older persons within the condition of Canadian society as a whole.

TRENDS AND PATTERNS IN HEALTH SERVICES IN CANADA OF PARTICULAR IMPORTANCE TO THE ELDERLY

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Department of National Health & Welfare
O T T A W A

This presentation is limited to health factors, but with a full appreciation of the importance of social and economic features and the need to provide effective arrangements which would encompass all of these areas. This committee has received and discussed a great many briefs, so that my remarks will be limited to particular aspects rather than trying to embrace the whole field. The complexity of the problem has been impressed upon you, and from the health point of view, the care of the elderly presents one of the greatest challenges.

Population Trends and Pertinent Health Statistics (See also Appendix I)

Your Committee has already received from the Dominion Bureau of Statistics and from a number of health agencies and organizations extensive data respecting the aged group in our population. I do not think it necessary to present additional data or to review the relevant statistics, but there are a few points which to me seem to be particularly important. At the time of the last census there were 1,391,153 people in Canada 65 years of age and over, and this represented 7.6% of the population. The numbers and proportion of the elderly in our population have increased, and will increase, both absolutely and relatively. In fact, population projections prepared for, and presented by the Royal Commission on Health Services indicate that the increase in the thirty-year period from 1961 to 1991 will be such that there will be in 1991 over three million of the elderly, and that they will be about 8.9% of the population. My first observation is by way of a demographic note. A percentage figure of this kind has to be used cautiously. The proportion of the elderly is not simply a matter of an inevitable trend, but to a substantial extent, reflects our relatively high fertility rate -- in fact, Canada's high birth rate has kept our proportion of elderly relatively low. In advanced countries such as ours, changes in mortality will have relatively little effect on population growth and fertility is the dominant factor. This in turn is a reflection of birth rates, marriage rates, and age at marriage.

In any case, this anticipated increase in the numbers and proportion of the elderly need cause no dismay, since the 8.9% level which has been suggested for 1991 has already been exceeded in a number of the advanced countries with which we like to compare ourselves, and I refer, for instance, to Britain and France and the Scandinavian countries, Denmark, Norway and Sweden. This has not prevented them from developing health and other services for their elderly, and in at least some instances, these are on a more generous scale than ours. We can learn from the diverse approaches and methods in these countries.

Another point I would make is that although we have experienced substantial gains in life expectancy, we should not be too optimistic about corresponding increases in the immediate future. Progress to date has been associated especially with control of infectious and respiratory diseases. The mortality rates for these are now relatively low, and among the elderly mortality is most commonly from cancer, cardiovascular diseases, and accidents and other violence. These have not proved as susceptible to control. An article in the Statistical Bulletin published by the Metropolitan Life Insurance Company presented some estimates of the years of life that would be gained in later years by specified reductions in mortality. Reductions of 10 to 20 per cent, which are suggested as possibilities within the decades immediately ahead, would result in gains of less than a year and a half, in the case of cardiovascular renal diseases and less than half a year for the malignant neoplasms. I mention this only to emphasize that the elderly group is going to continue to be a substantial part of our population, and that it will not change very much in age distribution within the group. While our immediate concern must be for those already in the aged group, we should realize the possibilities in planning preventive and other measures now that will make the life of the elderly in future years more healthful, so that they will be better able to enjoy the considerable number of years available to them. The three million old people the Royal Commission on Health Services projects for 1991 would be 35 to 65 years of age in 1961. It is in these years, and especially in the years from 40 to 45 on, that preventive medicine should, and may be, most effectively applied. Our attention should be directed to the preventive services, including diagnostic facilities and the treatment and rehabilitation resources necessary both to anticipate and to provide for the elderly.

Objectives of the Health Program

In dealing with this subject, one should have fairly clear cut objectives. The definition of health services provided by the World Health Organization, stressing as it does well-being, is particularly suited to an analysis of this subject. The primary purpose of all health programs is to prevent illness, but when it occurs the objective is, through early diagnosis, treatment, and rehabilitation, to restore the individual as quickly and completely as possible, to a maximum state of health.

When assessing health services for the elderly, there are several factors which need to be taken into consideration:

1. While the elderly suffer from acute conditions, chronic disease and long-term illness are the dominant conditions.

2. Socio-economic problems are frequently prominent.

3. Frailty is often important and must be taken into consideration in determining availability of service and the location in which it should be provided.

4. Changes in pattern of daily living, such as eating habits, recreation, and rest, create additional health problems which are frequently both physical and psychological.

5. Throughout life there are certain circumstances which facilitate or hinder programs for health supervision. For example, in the pre-natal, peri-natal, and post-natal periods, the mother and child are usually under the direct supervision of a physician. At school and work people are in groups and are more accessible to broad patterns of health care. However, it is the pre-school child and the elderly, because of their separation, that create special problems in the development of programs designed to prevent illness and minimize the effects of ill health. This committee is, of course, concerned with the elderly.

All of these factors need to be taken into account when one is considering health programs for older people.

Health Programs in the Department of National Health and Welfare of Importance to the Elderly

The department stresses a nation-wide approach and is particularly concerned with standards of care across the country. It recognizes that the major aspects of our health arrangements come within provincial jurisdiction, but at the same time, there is an important federal role. Federal participation in the development of health services in Canada can be discussed under three headings:

1. Financial Assistance

There are three major programs operating at present in the Department to provide financial assistance in the development and maintenance of health services in Canada:

(a) The Hospital Insurance and Diagnostic Services Act provides, through an insurance approach, financial assistance to the operating cost of hospital services.

The federal government provides funds to meet approximately 50% of the operating cost of general, chronic, and convalescent hospitals in this country. The federal expenditure for the present calendar year has been estimated to be $425,000,000.

(b) General Health Grants - These may be divided into three general purpose grants, namely General Public Health, Professional Training, and Public Health Research, providing general support of service, training and research respectively. In addition, there are five other grants providing assistance for special health fields; Mental Health, Child and Maternal Health, Cancer Control, Tuberculosis Control, Medical Rehabilitation and Crippled Children. The amount of federal funds available for General Health Grants in the present fiscal year is over $38,000,000. Of this amount, over $4,000,000. is spent on health research and in excess of $2,000,000. is for research in the field of chronic disease.

(c) Hospital Construction Grant - This Grant provides capital assistance for the new construction and renovation of hospitals, health units, nurses' residences, interns' quarters, etc. Expenditures in this capital area are expected to be over $20,000,000. in the present fiscal year.

2. Consultant And Advisory Services

A number of divisions and sections in the Health Branch of the Department provide consultant and advisory services which support programs of importance to the elderly. The Medical Rehabilitation Division has a primary responsibility in the field of long-term illness and has been designated as the Division which would provide leadership in this area. The Nutrition Division provides expert advice on nutritional problems. The Laboratory of Hygiene is particularly interested in diagnostic tests. Mental Health is concerned with psychosocial features. Research Development co-ordinates the extra-mural and intra-mural areas of health research in the Department, and health statistics and socio-economic research are provided by the Research and Statistics Division. These arrangements are co-ordinated through the office of the Director of Health Services.

An important starting point, as far as activity in the Department is concerned, was the setting up of a committee a few years ago to study chronic disease and the health problems of the aged. In the beginning it was decided that certain areas would need to be defined for investigation as the field is so vast and complex that specific terms of reference are needed in order to establish priorities and show progress. The first decision made by the committee was that while emphasis would be placed on health problems

of the aged, it was recognized that chronic disease affects all ages and the study was therefore not limited to old people. The areas that were chosen for investigation were as follows:

(1) Chronic disease of particular significance to public health;

(2) Hospitals and nursing homes for long-term patient care;

(3) Home care arrangements;

(4) Housing, nutrition, and activities;

(5) Other health resources required for chronic disease care.

It will be seen from this listing that while the primary emphasis was on the health aspects, these inevitably led to the consideration of associated welfare problems. Indeed, it was necessary not only to give consideration to social factors, but also to take into account financial implications. The study has been a most challenging one and the group has found that there are many gaps in our knowledge, and many areas that require further investigation.

3. Advisory Councils and Committees

The Minister of National Health and Welfare has a number of important advisory committees which provide a close working relationship between the Department, the provinces, and the various professional disciplines providing health services. The Dominion Council of Health is the senior Advisory Body and has a history dating back to 1919. The Advisory Committee on Hospital Insurance and Diagnostic Services is concerned with the operation of this important program and a number of other committees deal with special health areas. In addition to these continuing arrangements, certain ad hoc conferences and meetings have been held, and two recent examples are the Federal-Provincial Conferences on Smoking and Health, and Mental Retardation. A number of these groups are frequently concerned with health matters of interest to the work of this committee.

Two important points may be drawn from this description of Departmental activity. First, the complexity of the field is evident, and second, most of the programs are inter-related and must be integrated to form a composite picture.

The Report of the Royal Commission on Health Services - Volume I

It is not the purpose of this presentation to summarize this Report, but certain points might be mentioned as they

are pertinent to this discussion. The general philosophy and basic concepts of the Commission are set out in Chapter 1 of this Report, and a concise statement of the essential elements as seen by the Commission might be as follows:

> The Commission strongly supports the planned and co-ordinated development and maintenance of comprehensive health services in Canada with a substantial emphasis on training of personnel, availability of resources, and research. It believes that the pre-payment principle should be used extensively to finance these services. The general objective is the best possible health care for all Canadians, and the Commission sets out a Canadian Health Charter.

You will note the Commission stressed the planned and co-ordinated development and maintenance of comprehensive health services. While no special attention was given to aging, it would appear the Commission considered that comprehensive health services would embrace effective health programs for the elderly.

In addition, it supported the pre-payment principle as a technique of financing health arrangements and the three general methods proposed in the Report are at present in operation in the Department of National Health and Welfare. Furthermore, the importance of training and research is recognized. These are all features which need to be taken into consideration in the development of health services for the elderly.

The points discussed in the balance of this article represent the personal views of the author. The subject will be presented under the following headings, and related to the needs of the elderly.

1. Hospitals and Nursing Homes
2. Other Health Facilities and Services
3. Prevention - Early Diagnosis and Treatment
4. Patterns of Practice and Training of Health Personnel
5. Health Research
6. Need for long range planning, regular evaluation and Co-ordination of Health and Welfare services.

1. Hospitals and Nursing Homes

The Hospital Insurance and Diagnostic Services Program in Canada has an important influence on the development of hospital services in this country, and an understanding of the basic principles associated with it are essential to any broad appraisal of health facilities. It is much more than a fiscal arrangement, as emphasis is placed on effective utilization of resources, quality of care, and availability of services. No limitation is placed on length of stay in hospital as long as it can be established that there is a medical need for hospitalization. Over 98 per cent of the population of the country is insured under this arrangement. Practically all of the general, chronic, and convalescent hospitals in Canada are listed as participating hospitals. Therefore, with the exception of patients in mental hospitals and tuberculosis sanatoria, the hospital care of long-term illness is largely financed through hospital insurance, and the resources required for these services are identified with the program. This provides an opportunity for long range planning and co-ordination of hospital services..

Availability of beds

In 1960, there were 6.3 beds per thousand of population in general, chronic and convalescent hospitals in Canada, with provincial ratios varying from 4.3 to 8.4 (3 provinces have ratios in excess of 7). The estimated bed requirements in the United Kingdom for acute and chronic illness and maternity cases is 5.5 per thousand and the corresponding figure in the United States varies from 6 to 6.5. In Canada 0.9 of the 6.3 beds per thousand were listed for chronic or convalescent cases, with the remainder being designated as beds for acute cases. However, if the length of stay in public general hospitals is analyzed, it will be noted that about 5 per cent of the patients had stays of 30 days or more, and that these patients accounted for about 30 per cent of the total days of stay in hospital. This would imply that about 2 of the 6.3 beds per thousand population which are available in general hospitals are presently being used for long-term illness. The question which might be asked is whether this amount of care for long-term illness is being recognized in our present and future plans, and the bearing it would have on the number of beds required for acute care.

The use of beds in nursing homes also needs to be studied. In Canada, less than one bed (0.9) per thousand is in a nursing home, whereas in the United States, the figure is 1.6 beds in skilled nursing homes. The estimated need for long-term beds in skilled nursing homes in the United States is substantially higher than the figure they have attained. One of the problems is that nursing homes cover various levels of care, from units which provide skilled nursing, regular medical supervision, and rehabilitation, to

institutions which are almost entirely domiciliary in character. The decision which needs to be made is the level of nursing home care which would be provided in an institution considered a health facility. Should Canada consider the development of a system of skilled nursing homes which would be closely associated in a functional manner with hospitals, or should we continue with our present policy?

Thus, the inter-relationship of beds providing various levels of health care must be appreciated. Bed requirements are also affected by other community health and welfare resources. One of the most difficult, and probably the most neglected area, is the requirement of beds for long-term care. In determining the need, it might be better if we emphasized levels of health care which would endorse the principles of progressive care of the patient as applied to the whole pattern of resources. An example of a situation which occurred in a Canadian city is pertinent. An active rehabilitation program was introduced into a chronic disease hospital which had been dormant for many years. In a period of a few months one-third of the patients were ready for discharge but it was found that most of them had become separated from the community and the community did not have other arrangements for their care. Lack of movement of patients from this hospital to the community, in turn, created a pressure for more beds in the general hospital.

The foregoing appraisal does not take into account the beds required for mental illness. In 1960 there were 3.7 beds in mental hospitals in Canada per thousand of population. In addition, 1,334 beds were located in psychiatric units in general hospitals. Planners in the mental health field emphasize that the same criteria which apply to institutions for the physically ill can be applied to the care of mental illness and both systems should be integrated and co-ordinated into a comprehensive pattern for health care.

2. Other Health Facilities and Services

Other health facilities form an important part of our health care arrangements. There is good evidence that, in the changing patterns of the future, some of them may play a more prominent role. Community health services will be important in providing a continuum of care in a setting which encourages the maintenance of normal social patterns. Several might be discussed briefly.

Organized out-patient departments

With the exception of diagnostic services, organized out-patient departments in Canada have been largely restricted to teaching hospitals and are used chiefly by low-income groups. A similar situation was found in several other

countries but the opinion was repeatedly expressed that such a limited use of out-patient services and facilities was hampering the development of good patterns of medical care. Experienced planners believe that this situation should be corrected to ensure the maximal use of these resources. If this concept is accepted, out-patient departments in hospitals would provide services such as those for diagnosis and assessment, special treatment and rehabilitation. In doing this they would contribute valuable facilities and services for control of illness in the community.

Rehabilitation centers

Rehabilitation centers are located in a number of the larger cities in Canada and provide a valuable specialized service for the severely disabled. The in-patient components of these centers are included in the hospital insurance arrangements, and in five provinces the insurance program also covers out-patient care. These centers supplement rehabilitation in larger hospitals and are a valuable complementary arrangement. They should be closely associated with the hospital system and other community resources.

Day-and-night care centers

Although these centers were developed largely for the care of mental illness, it would appear that they could play a wider role for other patients who require diagnostic, therapeutic or rehabilitation services for a number of hours during the day or night. Their application to the care of chronic illness and rehabilitation deserves further consideration.

Hostels

Hostels have been established and associated with a few hospitals in Canada, particularly in situations where the hospital provides a specialized service, and patients come from a relatively large geographic area. The development of hostels has been limited in the past, but it may be desirable to re-appraise the value of these units, particularly in situations where the facilities provide a regional service.

Public health units and departments

Health agencies have a valuable role in terms of participation and co-ordination. They should be interested in primary and secondary prevention, rehabilitation and home care. Case finding and follow-up with referral services and a central registry might also form a part of a more comprehensive program. A major role for health agencies might be to

provide leadership and to work with other interested groups in the co-ordination of community resources to ensure that effective services are available.

Community mental health clinics

Community mental health clinics have been established in hospitals and as separate units. These clinics stress a community approach to psychiatric and allied services, they provide out-patient treatment and, in an increasing way, they sponsor programs for prevention and health education. Most have a close working relationship with voluntary agencies and other community mental health resources. A recent publication sums up the situation as follows: "Developments everywhere in psychiatry in recent years have witnessed a shift from exclusive preoccupation with in-patient services to the development of treatment services located in the community".

Home Care

There are a few examples of very good home-care programs in Canada. They have a common history in that they are popular, develop rapidly in the beginning to a modest stature, and then the volume of care levels off at a point which is meeting only a small part of the need. Various reasons have been given for this lack of progress.

First, the pattern of medical practice in Canada, and probably in the United States, places a heavy emphasis on hospital and office practice, eliminating all but an absolute minimum of house calls. Under these circumstances only a few medical referrals are made to the home-care program. This statement is not made in criticism of medical practice, as shortages in personnel and the need for the supporting services of a hospital make this trend inevitable. However, one wonders whether the pendulum has not swung too far in this direction and some correction could lead to a more extensive development of organized home-care arrangements.

Another pertinent factor is that the hospitals in our large metropolitan areas, particularly where there are universities, tend to be centrally placed and do not have a flow of patients from any particular geographic section. Under these circumstances it would be difficult to establish an effective hospital-based program, and this type of administration has been favoured by many in the past. Finally, some public health departments do not accept home care as a program area which comes within their terms of reference, and are unwilling to budget and provide a staff for these services.

On the positive side we have available in Canada the Victorian Order of Nurses, with an excellent reputation in the nursing field and with an apparent willingness to lend their skills to the development of comprehensive home care.

It would seem important, in the future development of health services, to take into account the potential of home care as a means of re-establishing a community focus for health services. This would be particularly important in the effective care of long-term illness, as it would help to minimize the social separation of the long-term patient.

3. Prevention - Early Diagnosis and Treatment

A large group of conditions which cause substantial disability in our elderly citizens are the results of degenerative or pathological processes which took years to become clinically significant. To minimize the disability caused by these diseases, preventive measures should frequently be taken at earlier stages in adult life. Until medical science discovers the cause and effective control of diseases such as cancer, cardiovascular conditions and glaucoma, the primary emphasis needs to be on secondary prevention (early diagnosis and treatment). However, it should be emphasized that good healthy living habits in terms of nutrition, rest and recreation, and avoidance of customs such as cigarette smoking have been shown to reduce the incidence of certain chronic diseases in a significant fashion.

The regular medical examination of the over-forties would create a heavy demand for medical services, and particularly if these examinations are thorough -- and unless they are, they are likely to be of little value. It may be necessary, therefore, to adopt a selective approach as far as regular medical check-ups are concerned, and focus attention on early signs and symptoms of the major conditions. In addition, the principle of well-oldster clinics could be fostered to encourage early general health supervision. Multi-phasic screening can be of considerable value for a number of conditions and the development of these techniques should be encouraged. All of this should be related to the planned development of comprehensive community health services.

In developing patterns for early diagnosis, the value of the hospital system should not be forgotten, as a substantial proportion of the population use these resources on an in-patient or out-patient basis. For example, the value of the admission X-ray to detect conditions of the heart and lungs is an important procedure in disease detection. Similarly, blood and urine examinations are useful for a variety of conditions. Efforts should be made to improve

our diagnostic capability through procedures such as these and in situations where they can be applied to large numbers of people. Health education is most important and is being used to alert the public on the early signs and symptoms of diseases such as cancer, diabetes and cardiac conditions. I would again like to stress the importance of detecting many of these disease conditions in early adult life, before significant disability results.

4. Patterns of Practice and Training of Health Personnel

The increase in the burden of chronic illness, population trends, changing social conditions and other factors indicate that patterns of health practice and the training of health personnel need to be carefully reviewed with these features in mind. In the section on home care, there was an indication of some features that created problems. There are others, and I would like to mention a few.

1. The decrease in the number of general practitioners is making it more difficult, particularly in metropolitan areas, to maintain the family doctor concept. The future role of the general practitioner in this country will have an important bearing on patterns of health practice.

2. The specialty of geriatrics probably needs greater emphasis. It might appear to be an anomaly to stress the need for general practitioners and then emphasize the role of the geriatrician. However, what is required is a balance between specialist and general medical services.

The established techniques for the training of health personnel may also have to be modified to recognize the emphasis which needs to be placed on chronic illness and socio-economic problems and their effects on health. The team concept is particularly important when one views the needs of the elderly. The team will involve not only the health professions, but others who can contribute to better arrangements for the care of the elderly. A good example of the team concept in health services is the geriatric clinic as developed by the Department of Veterans' Affairs. At this time, Mr. Chairman, I would like to pay tribute to the treatment and social services of this Department for the major contributions which they have made in the development of geriatric services and the research programs which they have sponsored particularly in a clinical setting.

5. Health Research

Health, today, encompasses virtually all the sciences concerned with man. Health research, therefore, spreads across a broad spectrum of subjects, professions, methods, agencies, institutions, opportunities, needs and responsibilities, including:-

1) Basic descriptions of normal or disease processes, in terms of biochemistry, etc. (related to preclinical research);

2) Extent of disease and how it is contracted and controlled (related to prevention);

3) Studies of the clinical methods for diagnosis and treatment, including rehabilitation;

4) Statistical evaluation of clinical results (related to improvement);

5) Public health - the way that man organizes himself and the resources of the environment to achieve optimum health;

6) Methods for applying knowledge to problems or services so as to achieve a better result in terms of people served, or cost, or other objectives. As Lord Rutherford is supposed to have said: "When you haven't enough resources, you've got to think".

Health research has paid off in better treatment, longer life span, improved environment, more efficient services. Just since the end of World War II the death rates from polio, appendicitis, and tuberculosis, to name only a few, have been reduced to about one-quarter of what they used to be among large groups of our population. Reductions of 40% or 50% have been achieved in deaths from acute nephritis, heart disease, asthma, dysenteries, and other diseases. Smaller reductions can be noted in anemias, infant deaths, and many others. Among diseases which restrict or cripple but do not usually kill, including the mental diseases, some progress has also been achieved, but much remains to be done. And there are still other diseases like most cancer, or the neuro-muscular disorders which still await a great break-through.

Research on how best to reach the most people with the most efficient services is a recent development which holds great promise for the future. Even when this research concerns infants and children it may influence the problems of old age, helping to avoid them in the true preventive spirit, or helping to lessen the disability, or aid in the

rehabilitation from them. Diseases requiring long treatment receive more emphasis every year in the basic and clinical and applied research that is going on in many countries. Aside from actual disease the study of health itself among older people in our social and cultural organization may pay great dividends.

Canada has a special opportunity to contribute to research related to aging, not by trying to carry out imitations of work done elsewhere, but by studying those problems which are notable in Canada. Why are some cancers more prevalent in one province than another? What is the significance of our particular geographical distribution of heart disease or liver disease? How can our health services be adapted to our resources and needs? Health research of the future, broadly based in this way, can be expected to make notable contributions to the health of Canadians, more and more of whom are getting into the older age groups. We have to be clear what we are trying to do or what problems we are trying to solve, and then get on with the job.

Health research -- basic, applied and operational -- should play a prominent role in our plans for the future.

6. Need for Long Range Planning, Regular Evaluation and Co-ordination of Health and Welfare Services

Medical science has shown great progress, particularly in the present century. Health services have become more complex and diversified. Many professional disciplines are involved and the public, as consumers and as participants through the many voluntary health agencies, is an active partner. In terms of cost, health services have become the seventh largest industry in Canada. Organization must keep pace with scientific progress but it should not lead to regimentation nor should it interfere with important desirable principles of practice. One of the most challenging areas for effective management is the care of the elderly particularly as related to chronic disease and long-term illness.

However, I would remind you that the diseases and disabilities common among the aged are not confined to them but vary among the age groups mainly in frequency -- the incidence and prevalence of their occurrence. A corollary of this fact is that the same kinds of services, preventive, diagnostic, treatment and rehabilitative, are required. The tenor of my remarks, then, is against isolation of the aged and fragmentation of services for them. Some important principles are as follows:-

1) Such services should be considered within the overall framework of health care. This does not mean that the planning needs to be delayed but it does mean that it should take place with a full appreciation of the interrelationships between the various facets of health care.

2) An important basic matter in the planned development of services, particularly with regard to older people, is the social objective behind the program. Is it to be our objective to enable as many old people as possible to spend the evening of their lives at home? If this is the decision then a primary emphasis would be placed on community health and welfare resources and out-of-hospital arrangements. The implementation of such a decision would have an important influence on future patterns of practice and the development of health resources. The practical application of such an objective would have many complex ramifications.

3) Integration. One of the greatest problems would be to reverse the trend towards the fragmentation of health services. Integration of arrangements would be most important and should include both physical and mental illness.

4) Although the primary focus would be on community arrangements, this would not minimize the need for regional, provincial and country-wide planning. This type of broad planning is particularly important in Canada, a large country with pockets of population and many sparsely inhabited areas. Many specialized services can be provided effectively in only relatively few centers.

5) The interrelationships of facilities and services make it essential to set up a co-ordinating mechanism at all levels of planning, and this should involve consumers as well as those providing the service.

6) Evaluation on a regular basis should be built into the organization. There is an important need to develop suitable health indicators to assess the burden of disease and the degree to which program goals are being met. The mass of routine statistics frequently confuses the issue, and selected indicators would serve as yard-sticks in evaluation.

7) Training and research should be considered as an integral part of this development. Operational research, which is the application of scientific methods to the administration, practice and procedures of health services, should play a much more prominent role in the future.

8) In all this development we should not lose sight of the fact that there is an art of medicine as well as a science, and that we are dealing with people within the mosaic pattern of their social environment.

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Excerpts from briefs presented to the Special Committee

Nursing